



**UNIVERSAL HEALTH INSURANCE:
WHY IT IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE
HEALTH SYSTEM AND WHY DESIGN MATTERS**

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Executive Summary

Thank you, Mr. Chairman, Ranking Member Gregg, and Members of the Committee for this invitation to testify on health care reform. The U.S. health care system performs poorly relative to other industrialized nations and relative to achievable benchmarks for health outcomes, quality, access, efficiency, and equity. In addition, where you live in the United States matters greatly in terms of access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. A major culprit in the inconsistent performance of the nation's health system is that we fail to provide health insurance to nearly 45 million people and inadequately insure an additional 16 million more. Universal coverage is essential to placing the system on a path to high performance. But the way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is ultimately able to make sustainable and systematic improvements in access to care, efficiency and cost control, equity, and quality of care.

The U.S. Health Care System Performs Poorly Compared with Other Countries

- The Commonwealth Fund Commission on a High Performance Health System's *National Scorecard on U.S. Health System Performance* found that out of a possible 100 points based on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries.
- The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care. The U.S. ranks last on infant mortality.
- Universal participation is essential for dramatic improvement in health care outcomes as well as overall performance of the U.S. health system.
- Not having stable, adequate coverage limits access to care. Out of five industrialized countries studied, the U.S. had the highest share of adults reporting that they had cost-related problems accessing needed health care.

- Our health insurance system is complex and inefficient, and it is based on incentives that are not always aligned with improving quality and efficiency. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending, compared with 5.6 percent in Germany and around 2 percent in France, Finland, and Japan. If the U.S. had had a level of administrative spending similar to that of France, Finland, and Japan, it would have saved an estimated \$97 billion on health care costs in 2004. Even reducing spending closer to that of countries with mixed public and private insurance systems like Germany and Switzerland would have saved an estimated \$32 billion to \$46 billion in that year.

There Are Wide Differences Across States in Access, Quality, and Costs

- The Commonwealth Fund Commission on a High Performance Health System released its *State Scorecard on Health System Performance* in June 2007. This report finds that where you live in the U.S. matters for access to care when it is needed, the quality of care, and the opportunity to lead a healthy life.
- Among the states, there is a nearly threefold variation in the percent of adults under age 65 who were uninsured in 2004–2005, ranging from a low of 11 percent in Minnesota to a high of 30 percent in Texas. Although in all states children are more likely than adults to have health insurance—thanks to Medicaid and the State Children’s Health Insurance Program (SCHIP)—the proportion of uninsured children ranges from 5 percent in Vermont to 20 percent in Texas.
- Across states, better access to care and higher rates of insurance are closely associated with better quality. States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care.
- States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of Medicare readmissions within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions.

Universal Coverage Is Essential to Achieving a High Performance Health System

- It is critical that the entire population be brought into the health care system in a way that ensures timely access to care across the full length of people’s lives.
- Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time in the right setting. Uninsured patients are more likely to receive wasteful and duplicative care because of a lack of care coordination.

- Quality and effectiveness measurement will not be meaningful unless those measures reflect the experience of a fully and continuously insured population and the work of providers who care for them.
- It will be impossible to realize efficiency in the operation of provider institutions and financing arrangements in the presence of billions of dollars in uncompensated care now paid for through pools of federal, state, and local government revenues and a highly uncertain amount of cost-shifting to other payers.

Design Matters: Key Questions to Consider in Evaluating Health Reform Proposals

- The way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is able to make sustainable and systematic improvements in access, efficiency, equity, and quality of care.
- Key questions that the public and policymakers might consider in evaluating health reform proposals:
 - Does the proposal improve access to care?
 - Does the proposal have the potential to lower cost growth and improve efficiency in the health care system?
 - Does the proposal improve equity in the health system?
 - Does the proposal have the potential to improve the quality of care in the health system?

Approaches to Health Care Reform: Key Features for Improving Access, Cost Control, Efficiency, and Quality

- The majority of recent proposals at both the federal and state levels build on the current system by connecting public and private insurance to ensure more coherent and continuous coverage over a person's lifespan.
- A framework for such an approach would create a new group insurance option similar to the Federal Employees Health Benefits Program (FEHBP), with income-related subsidies for the purchase of coverage; expand Medicaid and the State Children's Health Insurance Program (SCHIP) for lower-income families; and expand the Medicare program for older adults. It would require employers to offer coverage or pay into a fund and require individuals to obtain coverage.
- An alternate framework might include a more substantial role for Medicare. All uninsured people, people with private individual coverage, and most Medicaid beneficiaries would enroll in Medicare. Employers would pay 80 percent of their employees' premium, and workers would pay 20 percent of the premium. Employers

could opt out if they elected to provide an actuarially equivalent benefit. Individuals could not opt out. The program would subsidize both premiums and cost-sharing for families living below 500 percent of the federal poverty level.

Key components of health reform proposals to achieve high performance include:

- Insurers should compete on providing added value to the health system in greater quality and efficiency, rather than on segmenting or excluding poor health risks.
- Payers (private insurers and public programs) should negotiate with providers to create coherent policies and fair payment rates for health services and pharmaceutical products.
- Patient and provider incentives should be aligned to encourage use of all effective services, and avoid use of ineffective services, overuse of services, duplication of care, and waste.
- All patients and providers should be part of an organized care system that is accessible and accountable for patient health outcomes, preventive care, and care coordination.
- Information on the cost and quality of care should be transparent and publicly available.
- The health care system should be patient-centered and the health environment should be supportive of living healthy lives.
- The health system should be scientifically grounded.

Ultimately what is needed to move the health care system to high performance is a coherent set of policies with goals and properly aligned incentives that move all participants in the system in the same direction—toward improving access, quality, equity, and efficiency for everyone. It is critical that all adults and children are able to fully participate in a health care system that is well organized and is based on incentives that ensure that everyone receives the right care, at the right time, and in the right setting over their lifespan. It will not be productive in the long run if we focus overly on the impact of reform policies on the federal budget, or on the budgets of major corporations, or even the impact on our families' budgets. Instead, we can only move forward when we keep our eye on the number that really matters: the \$2 trillion that we spend as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets and should be the focal point of our collective energies as we develop coherent, consistent, and equitable health care policy.

Thank you.

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THE U.S. HEALTH CARE SYSTEM PERFORMS POORLY COMPARED WITH OTHER COUNTRIES

The Commonwealth Fund Commission on a High Performance Health System found that the U.S. health system falls far short of achievable benchmarks for health outcomes, quality, access, efficiency, and equity.¹ The Commission's *National Scorecard on U.S. Health System Performance* found that out of a possible 100 points based mostly on benchmarks that have been achieved within the U.S. or other countries, the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. scored particularly poorly on indicators of efficiency, with wide variation in cost and quality across the country and with much higher spending levels than other countries. The U.S. ranks 15th out of 19 countries on mortality from conditions "amenable to health care"—that is, deaths that could have been prevented with timely and effective care (Figure 1). In fact, 115 people per 100,000 Americans die from illnesses amenable to medical care before age 75, compared with 75 to 84 per 100,000 in the top three countries—France,

¹ C. Schoen, K. Davis, S. K. H. How, and S. C. Schoenbaum, "[U.S. Health System Performance: A National Scorecard](#)," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; The Commonwealth Fund Commission on a High Performance Health System, [Why Not the Best? Results from a National Scorecard on U.S. Health System Performance](#) (New York: The Commonwealth Fund, Sept. 2006).

Japan, and Spain. The U.S. ranks at the bottom among industrialized countries on healthy life expectancy at birth or at age 60. And out of 23 countries, the U.S. ranked last on infant mortality, with a rate of 7 infant deaths per 1,000 births, more than double the rates of the top three countries—Iceland, Japan and Finland—and well above the median rate for high-income industrialized countries (4.4 per 1,000 births) (Figure 2).

Access to Care

Access to care is a critical hallmark of health system performance, and the single most important factor determining whether people can obtain essential health care is whether they have health insurance coverage.² New studies also underscore how important comprehensive health benefits are to ensuring affordability of needed care and protection from medical costs.³ Even for those with health insurance, high out-of-pocket costs relative to income can undermine access and financial security.

The number of Americans without health insurance is climbing steadily. In 2005, 44.8 million people were uninsured, up from 43.5 million in 2004.⁴ People with low and moderate incomes are most at risk of lacking coverage through an employer and the most at risk of being uninsured. The Commonwealth Fund Biennial Health Insurance Surveys found that 53 percent of adults under age 65 who were living in families with incomes of less than \$20,000 spent some time uninsured in 2005 (Figure 3).⁵ Rates of uninsurance for people in more moderate-income families (\$20,000 to \$40,000) rose rapidly from 2001 to 2005, climbing from 28 percent to 41 percent. Health insurance premiums, meanwhile, have been increasing at rates three to four times faster than wages, placing tremendous strain on families and employers alike.⁶

² Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America* (Washington, D.C.: National Academies Press, June 2003).

³ J. Hsu, M. Price, J. Huang et al., “Unintended Consequences of Caps on Medicare Drug Benefits,” *New England Journal of Medicine* June 1, 2006 354(22):2349–59; R. Tamblyn, R. Laprise, J. A. Henley et al., “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons,” *Journal of the American Medical Association*, Jan. 24–31, 2001 285(4):421–29; P. Fronstin and S. R. Collins, [*The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience with High-Deductible and Consumer-Driven Health Plans*](#) (EBRI/The Commonwealth Fund, Dec. 2006); S. R. Collins, J. L. Kriss, K. Davis, M. M Doty, and A. L. Holmgren, [*Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Well-Being of American Families*](#) (New York: The Commonwealth Fund, Sept. 2006); K. Davis, M. M. Doty, and A. Ho, [*How High Is Too High? Implications of High-Deductible Health Plans*](#) (New York: The Commonwealth Fund, Apr. 2005).

⁴ Analysis of the revised March 2005 and 2006 Current Population Survey, Sherry Glied and Bisundev Mahato of Columbia University, for The Commonwealth Fund, May 2007.

⁵ S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, [*Gaps in Health Insurance: An All-American Problem*](#) (New York: The Commonwealth Fund, Apr. 2006).

⁶ G. Claxton, J. Gabel, I. Gil et al., “Health Benefits in 2006: Premium Increases Moderate, Enrollment in Consumer-Directed Health Plans Remains Modest,” *Health Affairs* Web Exclusive (26 Sept. 2006):w476–w485.

Universal participation is essential for dramatic improvement in health care outcomes as well as the overall performance of the U.S. health system. The *National Scorecard* tracks the proportion of under-65 adults who are insured all year and enjoy adequate financial protection. Inadequate protection, or being “underinsured,” is defined as having out-of-pocket medical expenses that exceed 10 percent of family income, or 5 percent for those whose incomes amount to less than twice the federal poverty level or whose insurance deductibles alone constitute 5 percent or more of income. As of 2003, 16 million adults were underinsured. Including those who were uninsured for any period of time during the year, 61 million adults, or 35 percent of all adults ages 19 to 64, were either uninsured or underinsured (Figure 4).⁷

Quality of Care

Not having stable adequate coverage, much like having no coverage at all, limits access to care. Out of five industrialized countries, the U.S. had the highest share of adults reporting that they had cost-related problems accessing needed health care (Figure 5). Forty percent of U.S. adults and 57 percent of adults with below-average incomes reported in 2004 that they went without care during the year because of the cost—four times higher than in the United Kingdom, a country with universal health insurance coverage and other protective policies.⁸ This problem is particularly acute and has long-term implications for uninsured adults with chronic health problems. The *National Scorecard* found that only one-quarter (24%) of uninsured adults with diabetes had received all three recommended services for diabetes in the last year, less than half the rate of privately insured adults with diabetes (54%) (Figure 6). Collins and colleagues found that that nearly 60 percent of non-elderly adults with a chronic health condition who had been uninsured for some time in 2005 did not fill a prescription or skipped a dose of their medication for their condition because of the cost, compared with just 18 percent of those who had coverage all year (Figure 7).⁹ The authors also found that more than one-third (35%) of uninsured adults with a chronic condition went to an emergency room or stayed overnight in a hospital for their condition, compared with 16 percent of those who were insured all year.

The U.S. also performs poorly when looking at the proportion of adults and children who receive recommended screening tests and preventive care. Rates are

⁷ C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, “[Insured But Not Protected: How Many Adults Are Underinsured?](#)” *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302.

⁸ C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Davis, K. Zapert, and J. Peugh, “[Primary Care and Health System Performance: Adults’ Experiences in Five Countries](#),” *Health Affairs* Web Exclusive (Oct. 28, 2004):w4-487–w4-503.

⁹ Collins, Davis, Doty et al., *Gaps in Health Insurance*, 2006.

particularly low among those lacking insurance coverage. Just 31 percent of adults who were uninsured all year received recommended screening tests and preventive care appropriate to their age and gender, compared with more than half of adults with coverage all year (Figure 8).¹⁰ Only one-third (35%) of uninsured children received both a medical and dental preventive care visit in the last year, compared with 63 percent of insured children (Figure 9). Similarly, fewer than one-quarter (23%) of uninsured children have a “medical home”—defined as having a regular doctor or nurse from whom they receive comprehensive and coordinated care—compared with more than half (53%) of privately insured children (Figure 10).

Efficiency

Not only does lacking coverage increase the potential for costly care down the road, it also impedes the delivery of efficient care once a person without coverage enters the health care system. People with and without health insurance may see multiple physicians in multiple institutions and face the inherent difficulties of transferring information and medical records among the providers involved.¹¹ Breakdowns in the coordination of care can lead to inefficient care, such as the duplication of tests when records become lost. Having gaps in health insurance coverage can exacerbate such coordination problems, particularly when individuals have multiple chronic conditions. The U.S. scores poorly on care coordination compared with other countries. Among adults in poor health, the U.S. had the highest rates of test results or records not being available at the time of their appointment in the last two years, and the second-highest rates of receiving a duplicate test (Figures 11, 12).¹² On both measures, people without insurance reported the highest rates of problems.

Insurance Administration

Private health insurance in the U.S. is characterized by complex benefit and cost-sharing designs and high rates of turnover in plan enrollment. Health plans also incur significant marketing and underwriting costs. The U.S. is unique in that a significant percentage of the cost of health insurance goes to non-health activities: an estimated 10 and 40 percent of premiums, depending on the market and state, is consumed by claims

¹⁰ Schoen, Davis, How, Schoenbaum, “U. S. Health System Scorecard,” 2006; Fund Commission, *Why Not the Best?* 2006.

¹¹ C. Schoen, R. Osborn, P. T. Huynh, M. M. Doty, K. Zapert, J. Peugh, and K. Davis, “[Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries](#),” *Health Affairs* Web Exclusive (Nov. 3, 2005):w5-509–w5-525; A. Gauthier, S. C. Schoenbaum, and I. Weinbaum, [Toward a High Performance Health System for the United States](#) (New York: The Commonwealth Fund, Mar. 2006).

¹² Schoen, Davis, How, Schoenbaum, “U.S. Health System Scorecard,” 2006; Fund Commission, *Why Not the Best?* 2006.

administration, underwriting, marketing, profits, and other administrative costs.¹³ In fact, costs of insurance administration are the fastest-growing component of national health expenditures. Between 2000 and 2005, net insurance administrative overhead, including both administrative expenses and insurance industry profits and public insurance program costs, rose by 12 percent per year compared with an average of 8.6 percent for overall spending (Figure 13).¹⁴

Indeed, the U.S. leads all other industrialized countries in the share of national health expenditures it devotes to health care administration. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending. Similar spending in other industrialized countries ranged from 5.6 percent of national health expenditures in Germany to around 2 percent in France, Finland, and Japan (Figure 14).¹⁵ Davis and colleagues estimate that if the U.S. had had a level of administrative spending similar to that of France, Finland, and Japan it would have saved \$97 billion on health care costs in 2004.¹⁶ Even reducing spending closer to that of countries with mixed public and private insurance systems, like Germany and Switzerland, would have saved an estimated \$32 billion to \$46 billion in that year.

THERE ARE WIDE DIFFERENCES ACROSS THE 50 STATES AND DISTRICT OF COLUMBIA IN ACCESS, QUALITY, AND COSTS

Where you live in the U.S. matters: for access to care when it is needed, the quality of that care, and the opportunity to lead a healthy life. This was the recent finding of the Commonwealth Fund Commission on a High Performance Health System's *State Scorecard on Health System Performance*, released in June 2007. The following section draws heavily from this report, which was authored by Joel C. Cantor, Dina Belloff, Cathy Schoen, Sabrina K. H. How, and Douglas McCarthy and can be read in full on the Commonwealth Fund Web site, www.commonwealthfund.org.¹⁷

The *State Scorecard* documents wide, state-by-state variation across key dimensions of health system performance: access, quality, avoidable hospital use and costs, equity, and healthy lives. While no single state performs at the top across all categories, some states far surpass others. States in the Northeast and Upper Midwest

¹³ J. Gabel, K. Dhont, and J. Pickreign, [*Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*](#) (New York: The Commonwealth Fund, May 2002).

¹⁴ K. Davis, C. Schoen, S. Guterman, A. Shih, S. C. Schoenbaum, and I. Weinbaum, [*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*](#) (New York: The Commonwealth Fund, Jan. 2007).

¹⁵ Schoen, Davis, How, Schoenbaum, "U.S. Health System Scorecard," 2006; Fund Commission, *Why Not the Best?* 2006.

¹⁶ Davis, Schoen, Guterman et al., *Slowing the Growth*, 2007.

¹⁷ J. C. Cantor, D. Belloff, C. Schoen, S. K. H. How, and D. McCarthy, [*Aiming Higher: Results from a State Scorecard on Health System Performance*](#) (New York: The Commonwealth Fund, June 2007).

often rank high in multiple areas (Figure 15). In contrast, states with the lowest rankings tend to be concentrated in the South. The striking variability across states adds up to substantial human and economic costs for the nation. The *State Scorecard* estimates that if all states could do as well as the top states, 90,000 lives could be saved annually, 22 million additional adults and children would have health insurance, and millions of older adults, diabetics and young children would receive essential preventive care. In addition, Medicare could save \$22 billion a year if high-cost states reduced their spending to levels of the average states.

Insurance Coverage Differs Dramatically Across States

Across states, the proportion of uninsured adults under age 65 has risen dramatically over the five-year period 1999–2000 to 2004–2005 (Figure 16).¹⁸ The *State Scorecard* finds that the number of states where 23 percent or more of the adult population is uninsured *tripled*, from four to 12.¹⁹ In sharp contrast, children fared much better during the same period (Figure 17). Thanks to federal support of Medicaid and state expansions through the SCHIP program, the percent of children who are uninsured declined in most states. In only three states were more than 16 percent of children uninsured in 2004–2005, compared with 10 states in 1999–2000.

Insurance coverage rates differ sharply across states.²⁰ If all states achieved the level of coverage in leading states, 17.2 million more adults and 4.4 million more children would have insurance. The number of uninsured across the nation would be halved.

- Among the states, there is a nearly threefold variation in the percent of adults under age 65 who were uninsured in 2004–2005, ranging from a low of 11 percent in Minnesota to a high of 30 percent in Texas (Figure 18).
- Although in all states children are more likely than nonelderly adults to have health insurance, the proportion of uninsured children varies from a low of 5 percent in Vermont to a high of 20 percent in Texas—a rate four times higher.
- Reflecting differences in state coverage policies, trends in coverage for adults and children have diverged sharply over the past five years. In all but 12 states, the uninsured rate for children has declined. In all but six states, the uninsured rate for adults under 65 has *increased*.

¹⁸ Ibid.

¹⁹ These data are the most recent state data currently available. The U.S. Census department recently announced it will be reissuing insurance data and decreasing the national uninsured count by about 1.8 million. The department noted the trends remain up. Adjusted state data and trends are not yet available.

²⁰ Cantor, Belloff, Schoen et al., *Aiming Higher*, 2007.

- Alabama stands out in the South for its particularly low uninsured rates for children. In fact, along with Vermont, Massachusetts, Hawaii, Iowa, Michigan, and Nebraska, it is one of the seven states with the lowest rates of uninsured children. Alabama's success in covering children, despite being relatively poor and having low levels of private, job-based insurance coverage, reflects its decision early on to expand SCHIP coverage for children in families with incomes up to 200 percent of the poverty level and to pursue aggressive enrollment policies.

Access to Health Care and Quality Are Closely Linked

The *State Scorecard* finds that across states, better access to care and higher rates of insurance are closely associated with better quality (Figure 19).²¹ States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care, as well as other quality indicators. Four of the five states with the best access-to-care rankings (Massachusetts, Iowa, Rhode Island, and Maine) are also among the highest on quality of care. States with low-quality rankings tend to have high rates of uninsured residents. Notably, the five top-ranked states overall (Hawaii, Iowa, New Hampshire, Vermont and Maine) all have high rates of insurance coverage, with nearly 90 percent of working-age adults insured. In contrast, in the five lowest-ranked states (Nevada, Arkansas, Texas, Mississippi and Oklahoma), the share of adults insured ranges between 70 and 78 percent.

This cross-state pattern points to the importance of affordable access as a first step to ensure that patients obtain essential care and receive care that is well coordinated and patient-centered.²² In states where more people are insured, adults and children are more likely to have a medical home and receive recommended preventive and chronic care. Identifying care system practices as well as state policies that promote access to care is essential to improving quality and lowering costs.

In most states, the quality of care varies by income and insurance, with lower income and lack of insurance linked to lower quality.²³ But such gaps are widest in states that perform poorly on indicators of quality and access overall. Gaps are particularly wide in terms of receipt of preventive care (Figure 20). On average across the nation, 78 percent of uninsured and 71 percent of low-income adults age 50 and older did not receive recommended preventive services, compared with 59 percent of insured and 54 percent of higher-income adults. A similar pattern exists among diabetics. On average, 67 percent of low-income diabetics did not receive basic care according to guidelines for their condition.

²¹ Ibid.

²² Ibid.

²³ Ibid.

The extent to which children have a medical home also depends on their family's income and their insurance status.²⁴ Top-ranked states on equity generally performed well for all children, including those in low-income families or without health insurance (Figure 21). In most states, variation on many indicators is much greater among uninsured than insured populations. For instance:

- The proportion of insured adults who reported not seeing a doctor because of cost was less than 14 percent in all states. Among the uninsured, the proportion reporting this ranged from a low of about one of four uninsured residents in North Dakota and Hawaii to a high of 52 percent in the five states with the largest gap for this indicator.
- Across the nation, on average only 14 percent of adults with insurance coverage reported not having a usual source of care. Among the uninsured, proportions without a usual source of care ranged from 38 percent in the states with the smallest disparities to 70 percent in the states with the largest disparities.

Higher Quality Does Not Mean Higher Costs

The *State Scorecard* finds that annual costs of care vary widely across states, with no systematic relationship to insurance coverage or ability to pay as measured by median incomes.²⁵ Moreover, there is no systematic relationship between the cost of care and quality across states. Some states achieve high quality at lower costs.

States with higher medical costs tend to have higher rates of potentially preventable hospital use, including high rates of Medicare readmissions within 30 days of discharge and high rates of admission for complications of diabetes, asthma, and other chronic conditions (Figure 22). Reducing the use of expensive hospital care by preventing complications, controlling chronic conditions, and providing effective transitional care following discharge has the potential to improve outcomes and lower costs.

UNIVERSAL COVERAGE IS ESSENTIAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM

The findings of the *National Scorecard* and *State Scorecard* point strongly to the need for the U.S. to insure all of its residents in order to move effectively to a higher level of overall health system performance. The U.S. consistently ranks well in back of the pack of industrialized nations—all of whom have varying forms of universal health insurance—on key measures of performance, including preventable mortality, life expectancy, and infant mortality.

²⁴ Ibid.

²⁵ Ibid.

Similarly, the 10 overall leading states in the *State Scorecard* have the lowest rates of uninsurance among adults and children. Moreover, many have among the most extensive publicly sponsored insurance programs, with income thresholds that support low- and modest-wage workers and their families. For example, only eight states in the country have SCHIP and Medicaid programs that cover children up to 300 percent of poverty, and five of those states rank among the top 10 states overall in the *Scorecard*.

In addition, two states in the top 10 overall leaders, Hawaii and Maine, have attempted to extend health insurance to most of their residents. Hawaii, which ranks first in the *State Scorecard*, mandated in 1974 that employers—with a few exceptions, such as seasonal employers and government services—provide insurance to all employees working more than 20 hours a week.²⁶ Maine's Governor John Baldacci signed the Dirigo Health Reform Act (PL 469) into law in June 2003. Dirigo aims to make quality, affordable health care available to every Maine citizen within five years and to initiate new processes for containing costs and improving health care quality.

It will be very difficult for the U.S. to gain control of health care cost inflation associated with chronic illness through the timely use of preventive care and chronic disease management when millions of families lack the financial means to regularly access these services before their conditions become serious and expensive. It is critical that the entire population be brought into the health care system in a way that ensures access to care across the full length of people's lives.

Uninsured and underinsured patients and the doctors who care for them are far from able to obtain the right care at the right time in the right setting. Uninsured patients are more likely to receive wasteful and duplicative care because of a lack of care coordination. Meaningful medical homes—not just places to obtain primary care, but ones that are able to ensure that patients get the prescription drug therapy, follow-up tests, and specialized care that they need—will never be achievable unless families have insurance coverage to provide them with equitable access to the full range of health care that will be required over the course of their lives.

Quality and effectiveness measurement will not be meaningful unless those measures reflect the experience of a fully and continuously insured population and the work of providers who care for them.

It will be impossible to realize efficiency in the operation of provider institutions and financing arrangements in the presence of billions of dollars in uncompensated care now paid for through pools of federal, state, and local government revenues and a highly uncertain amount of cost-shifting to other payers.

²⁶ K. Davis, [*Spreading State Success*](#) (New York: The Commonwealth Fund, June 2007).

DESIGN MATTERS: KEY QUESTIONS TO CONSIDER IN EVALUATING HEALTH REFORM PROPOSALS

Expanding health insurance coverage to people who now lack it is a necessary but not a sufficient condition for achieving high performance. The way in which a universal coverage system is designed will matter greatly in terms of whether the overall health system is able to make sustainable and systematic improvements on the dimensions measured in the *National Scorecard* and *State Scorecard*: access to care, efficiency and cost control, equity, and quality of care. With these goals in mind, the following are some key questions that the public and policymakers might consider in evaluating health reform proposals:

- Does the proposal improve access to care?
 - How many people would become newly insured under the proposal?
 - Does the proposal improve coverage for people who currently have inadequate insurance, with high costs or limited benefits?
 - Does the proposal make enrollment easy and seamless so that it is easy to get enrolled and stay enrolled?
- Does the proposal have the potential to lower cost growth and improve efficiency in the health care system?
 - Does the proposal have the potential to achieve savings in national health spending?
 - Does the proposal pool health care risks broadly?
 - Are specific provisions aimed at slowing cost growth?
- Does the proposal improve equity in the health system?
 - Does the proposal improve equity in access to comprehensive health care services?
 - How does the proposal affect family health care spending across the income spectrum?
- Does the proposal improve the quality of care in the health system?
 - Is the insurance system oriented to towards improving health care quality?
 - Are there specific provisions aimed at improving quality and efficiency?

APPROACHES TO HEALTH CARE REFORM: KEY FEATURES FOR IMPROVING ACCESS, COST CONTROL, EFFICIENCY, AND QUALITY

Current proposals to expand health insurance range in scope from targeted efforts that would cover a defined group of people, such as children, older adults, people with work-ending disabilities, and small businesses, to those that aim to expand coverage options for everyone. Proposals targeted to defined groups of people would have far less impact on the nation's uninsured problem than would more universal coverage proposals. Beyond their potential ability to significantly reduce uninsurance in the targeted population or organizational group, incremental reforms should be critically evaluated in terms of whether they are a component of a long-range plan to reach universal coverage. Do these proposals provide a sound and efficient insurance foundation with a defined road map for achieving affordable, comprehensive coverage? Do they cover the most at-risk populations first?

Current proposals that aim to expand coverage to everyone range from those that are built primarily on public insurance programs like Medicare to those that would rely on private insurance. The majority of recent proposals at both the federal and state levels envision a mixed private and public insurance system that builds on and expands existing public insurance programs and the employer system, and offers new options for people who lack access to either form of coverage.²⁷ Such new options include merged individual and small-group markets as in Massachusetts's Commonwealth Care Connector, the Federal Employees Health Benefits Program (FEHBP), a public insurance plan such as that offered through Medicare, or new incentives to purchase coverage in the existing individual market.

Framework for a Mixed Private–Public Approach. An example of a framework for a mixed private–public approach was laid out by Karen Davis and Cathy Schoen in the journal *Health Affairs* in 2003.²⁸ A modified version of this framework builds on the existing system and includes an employer mandate, an individual mandate, and a new group insurance option that would operate like FEHBP. Employers would be required to either offer a benefit plan meeting minimum standards or contribute 5 percent of payroll to a fund that would cover their employees under the new group option.

The framework would also expand SCHIP to include all children, parents, and adults up to 150 percent of poverty. In addition, to reduce adverse selection in the new group option, a new Part E would be added to Medicare to expand coverage to those age 60 and over who lack access to employer coverage and to dependents of current

²⁷ J. L. Lambrew and J. Gruber, "Money and Mandates: Relative Effects of Key Policy Levers in Expanding Health Insurance Coverage to All Americans," *Inquiry*, Winter 2006/2007 43(4):333–44.

²⁸ K. Davis and C. Schoen, "[Creating Consensus on Coverage Choices](#)," *Health Affairs* Web Exclusive (Apr. 23, 2003):w3-199–w3-211.

beneficiaries; the two-year waiting period before the disabled can join Medicare would be eliminated. Medicare Part E, which would consolidate Medicare Parts A, B, D, and supplemental coverage into one benefit, would also be available through the new group option.

The new group option would be open to firms with fewer than 100 employees and individuals without access to employer-based coverage or Medicare. They could choose to enroll in Medicare Part E or in other private integrated plan options offered through the new option, like those of Kaiser Permanente. Medicare Part E would be the only fee-for-service option available. All tax filers would be required to show proof of insurance coverage at the time of filing. Those whose employers do not offer coverage and whose incomes fall above 150 percent of poverty would be eligible for tax credits to cover premiums in the new group option in excess of 5 percent of income, or 10 percent for higher-income families.

Other features include a requirement that companies provide coverage to dependents up to age 26 under their parent's policies, and that companies extend coverage to employees for up to two months after a loss of a job, with the federal government subsidizing 70 percent of the premium.

Framework for an expanded Medicare. A variation on the mixed private–public model might include a more substantial role for Medicare. In such a framework, all uninsured and people with private individual coverage would be enrolled in Medicare. Medicaid beneficiaries, except for those also covered under Medicare (i.e., dual-eligibles), would also be enrolled in program. Employers electing to provide an actuarially equivalent benefit could opt out of the system. People in covered groups would not have the option of declining coverage under the program, except in cases where their employer has exercised its option to provide coverage separately.

Premiums would be community–rated, so that the premium would be uniform for all participants and would vary only with family composition. There would be no adjustment for risk characteristics. Community-rated premiums would be based upon expected costs for newly enrolled people, assuming that providers would be reimbursed at Medicare payment levels.²⁹ Employers would pay an amount equal to 80 percent of premium, prorated for part-time workers, and workers would pay 20 percent of the premium. Non-workers would pay 100 percent of the premium. The program would subsidize both premiums and cost-sharing for families living below 500 percent of the federal poverty level. Savings to states from the elimination of Medicaid for the covered population would be transferred to the program (i.e., state maintenance of effort).

²⁹ Medicare payment levels are typically above Medicaid payment levels but less than what private payers pay for comparable services.

Medicare would remain distinct in the system. The benefits package would cover the services now covered under the Medicare program, plus certain services not now covered under Medicare. Current Medicare recipients would be covered for the same services the program now covers but also would be eligible for the cost-sharing and out-of-pocket spending subsidies under the newly expanded program.

The inclusion or omission of key features in both general approaches has significant implications for the number of people covered, the cost to federal and state governments and the overall health system, equity in access and financing, and improvements in efficiency and quality. These are discussed below.

Access to Care

How many people would the proposal cover? Proposals that aim to cover nearly everyone vary in terms of their effectiveness, which previously uninsured people would gain coverage, and what their source of coverage would be. Jeanne Lambrew and Jonathan Gruber argue that the most important features in the mixed private–public approaches in terms of impact on coverage are: 1) whether employers are required to offer and contribute to coverage; 2) whether individuals are required to obtain coverage; and 3) the structure and generosity of public subsidies, including expansions of public programs.³⁰ Other key features that matter, in terms of impact on people covered, include the degree of risk pooling, and whether there is an autoenrollment mechanism.

In simulation exercises of several variations on mixed private–public approaches, Lambrew and Gruber found that the inclusion of an individual mandate is critical to achieving universal coverage. An employer mandate alone, even with generous subsidies, falls short of universal coverage, since it fails to reach those with weak connections to the labor force and those for whom the subsidies are not sufficient incentive to enroll. Employer mandates that exclude small firms would cover even fewer uninsured people.³¹

By themselves, subsidies provided to individuals and small firms to help them voluntarily buy-in to a new group option will, in the absence of an employer or individual mandate, fall far short of universal coverage. Moreover, this may, ironically, contribute to people with employer-based coverage becoming uninsured. Lambrew and Gruber find that a proposal that combined a new group option, Medicaid expansion, and generous subsidies to firms and individuals to buy-in to the new option would cover only about 20 percent of the uninsured. This is partly because some small firms with lower-wage workers might drop coverage if they knew their employees had a new option. In addition,

³⁰ Lambrew and Gruber, “Money and Mandates,” 2007.

³¹ S. R. Collins, K. Davis, and J. L. Kriss, [*An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part I, Insurance Coverage*](#) (New York: The Commonwealth Fund, Mar. 2007).

the voluntary nature of individual enrollment would result in large numbers of people continuing to go without coverage.

Another important feature is the structure of the subsidy itself, and whether it would keep pace with inflation over time in medical costs. Subsidies that cap premiums and out-of-pocket spending as a share of income would maintain their value over time. Some other approaches, such as a fixed tax deduction for those who enroll in employer coverage or individual coverage, would necessarily have to be structured so as to maintain their value in the face of rising costs and premiums. For example, income tax deductions that rise less slowly than premiums would have the potential to cover more uninsured people in the first years of the proposal than in future years, when premiums are more likely to exceed the cap and thus be more expensive to taxpayers.

In terms of where people would gain coverage under a mixed private–public approach with employer and individual mandates, most people would maintain their current source of coverage either through their employers or public programs.³² There would be a large shift to the new group option from the current individual market, an increase in public program coverage, and an increase in employer coverage as a result of the employer and individual mandates.³³

An expanded Medicare approach like that described above would likely cover everyone. Individuals could not opt out. Prior analyses of such an approach also finds that most employers would not elect to opt out, since it is unlikely that firms could negotiate premiums with rates more favorable to what the government could negotiate.³⁴ Thus, it is anticipated that most people would have coverage through Medicare, even with the employer opt-out.

Do the proposals improve coverage for people who currently have inadequate coverage, entailing high costs or limited benefits? Proposals that set a floor on acceptable levels of health benefits would improve coverage for millions of people who are currently underinsured and provide comprehensive access to care for people who become newly insured. Many recent proposals have required that that qualifying health plans in new group options would have to be equivalent in value to the Blue Cross/Blue Shield Standard Plan offered to federal employees and members of Congress under FEHBP. In addition, many proposals, including the mixed private–public approach and the Medicare expansion described above, would also cap out-of-pocket costs as a share of income and/or subsidize premiums.

³² Davis and Schoen, “Creating Consensus,” 2003.

³³ Lambrew and Gruber, “Money and Mandates,” 2007.

³⁴ Collins, Davis, and Kriss, *Congressional Health Care Bills*, 2007.

Some proposals, by expanding access to Medicaid and SCHIP, would improve existing benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults with low to moderate incomes. In the case of both the mixed private–public framework and the expanded Medicare approach, requiring a comprehensive set of benefits and lower cost-sharing in the new program would improve coverage for existing Medicare beneficiaries who face substantial cost-sharing. In contrast, recent proposals that provide incentives for coverage in the private individual insurance market would move some people into plans with more limited benefits or higher deductibles.

Does the proposal make enrollment easy and seamless so that it is easy to get enrolled and stay enrolled? Proposals that would enroll people automatically through the tax system or at birth, such as the mixed private–public approach and the expanded Medicare framework described above, are the most likely to ensure that people become enrolled and remain enrolled. The fact that most people would be covered under one system under the expanded Medicare approach would also help ensure that people remain enrolled, regardless of changes in income, age, health status, or employment status.

More incremental proposals targeted to certain groups of people or income groups face the inherent challenge of enrolling all those who are eligible. This has plagued both Medicaid and SCHIP, resulting in substantial churning when people are dropped if they fail to re-enroll in six or 12 months, depending on the state they live in, as well as millions of adults and children being eligible but not enrolled. Prior analyses have found that adding provisions to increase enrollment and retention in targeted programs do increase enrollment, but that many adults and children eligible for the programs would remain uninsured.³⁵ This reveals the limited ability of targeted expansions to cover all of those eligible when eligibility is determined by income, in the absence of a more comprehensive national system of coverage, which would automatically enroll people into the coverage for which they are eligible.

Efficiency

Does the proposal have the potential to achieve overall system savings?

The estimated savings to the overall health system from insuring everyone have the potential to be substantial, relative to incremental approaches. Primarily, these reflect the significant potential savings in the cost of insurance administration, particularly in the case of the expanded Medicare framework, but also in the mixed private–public approaches where group coverage replaces the non-group insurance market. The current

³⁵ Ibid.

system is highly fragmented and complex, with people receiving coverage through multiple, competing insurance carriers. Covering everyone through Medicare would substantially reduce this complexity. But replacing the individual market with group forms of coverage could also lead to substantial savings. As a share of premiums, insurance administrative costs range from 2 percent under Medicare, 10 percent for employer group coverage, and 25 to 40 percent for coverage purchased in the individual insurance market.³⁶

Do proposals pool health care risks broadly? How a proposal is structured and how broadly risks are pooled has a fundamental impact on costs. Recent proposals that would provide an equivalent capped income tax deduction for insurance gained through employers or through the individual market would have the effect of moving more people into the individual market. Other proposals would also encourage non-employer coverage in similar ways, but would create new group options and impose restrictions on individual underwriting. Prior estimates have shown the differential impact on the costs of insurance administration to be substantial; proposals that increase coverage through the individual market have the potential to increase administrative costs, while those that provide group options have the potential to significantly lower overall administrative costs.³⁷

Incremental approaches that attempt to address the ongoing affordability crisis plaguing small companies that buy coverage through the small group market by regulating or deregulating the market are significantly challenged by the perverse effects of adverse selection.³⁸ Proposals that would allow groups of companies to bypass state insurance regulations, such as community rating, are estimated to make small group coverage more affordable for companies with a young and healthy workforce, but they also significantly increase premiums for less healthy consumers or companies with older workers. But proposals that establish pools for small businesses with premium protections, federal reinsurance, and tax credits can have the unintended effect of attracting companies with less healthy and older workforces while companies with healthier workforces look elsewhere. In addition, it has proven very difficult to attract large numbers of small employers into such pools even with generous subsidies, in the absence of mandates.³⁹ It is important that proposals attempt to broadly pool people to avoid the unhealthy dynamic in the small and non-group market that occurs when groups of people can be divided according to age or health risk.

³⁶ K. Davis, B. S. Cooper, and R. Capasso, [*The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare*](#) (New York: The Commonwealth Fund, Nov. 2003).

³⁷ Collins, Davis, and Kriss, *Congressional Health Care Bills*, 2007.

³⁸ Ibid.; unpublished analyses by the Lewin Group.

³⁹ Lambrew and Gruber, "Money and Mandates," 2007.

Broad risk pooling is also crucial on equity grounds. The proposals that attempt to cover people through existing small or non-group markets ultimately confront the central dynamic governing those markets—the powerful incentive on the part of carriers to protect against health risk. Proposals that would increase incentives for people to gain coverage through the individual insurance market need to address the significant variation in premiums and in the value of benefits that characterize that market. The value of tax credits or tax deductions would likely vary for people who live in different parts of the country and who are of different ages, health status, and gender—not to mention people with severe health problems for whom no insurer will write a policy. In general, proposals that would be built on existing and new group insurance options would avoid these problems, particularly with the addition of an individual mandate. The private small group–non-group insurance connectors established under some proposals, and implemented in Massachusetts, might, without proper safeguards, be more at risk for adverse selection and premium escalation. Protections for these private purchasing mechanisms would include mandatory participation, community rating for the full state market as well as for the insurance connectors, and adequate federal reinsurance.

Are there specific provisions aimed at slowing cost growth? Given the rapid rise of health care costs and its growing importance in the federal budget, proposals to expand health insurance should include features directed towards leveling cost growth.⁴⁰ Proposals might include features that would be directed towards improving efficiency in insurance administration and payment, such as requirements regarding the share of premiums devoted to medical care, reducing Medicare Advantage payments, establishing public–private payer purchasing collaborative to negotiate lower pharmaceutical prices, reduce prices for overused services, and have all payers adopt Medicare DRG payment rates. Other possibilities for cost control might include provider payment incentives directed towards reducing variation in costs, such as paying for episodes of care and identifying and reducing cost growth in high-cost regions of the country.

Equity and Affordability

How do the bills affect family health care spending across the income spectrum? The way in which new premium subsidies, tax credits, or tax deductions for the purchase of health insurance are designed has significant implications for how costs or savings accrue across households. Both the private–public mixed approach and expanded Medicare approach described above have significant premium and cost

⁴⁰ P. Orszag, *Health Care and the Federal Budget: Issues and Challenges for Reform*, Invited Testimony, U.S. Senate Budget Committee, Hearing on “Health Care and the Budget: Issues and Challenges for Reform,” June 21, 2007.

protections for consumers such that lower-income families pay less than do higher-income families. Cost savings to households also arise from people becoming insured, as well as from the new protection from out-of-pocket costs and premiums that benefit currently insured families who have high out-of-pocket costs and premiums relative to their incomes.

Recent proposals that would provide a new standard income tax deduction for private insurance differ considerably in how progressively the deduction is structured and whether there are additional premium subsidies for lower-income families. Proposals that would extend a standard income tax deduction that does not vary by income and that does not include additional premium support will be most valuable to high-income families.⁴¹

Do the proposals improve equity in access to health care? Proposals that aim to achieve near-universal coverage with comprehensive benefits and cost protections for families with low and moderate incomes will go the farthest in providing equal financial access to the health care system. More targeted proposals, such as proposals to expand coverage for children and lower-income families, would make small but necessary improvements in providing equal access to the health system for millions of children and adults who face financial barriers to care.

Quality

Is the insurance system oriented towards improving health care quality? A significant barrier to improving the quality of health care nationally is the large number of people who lack meaningful health insurance coverage and are therefore largely outside the system. Those proposals that would cover the most people would help ensure that the population as a whole has access to preventive care and timely essential medical care across the lifespan.

But the ways in which people are insured, the systems that evolve to achieve near-universal coverage, and the role of insurance carriers will be important determinants of whether significant and systematic improvements in quality can be achieved across the country. More centrally organized proposals would enable the nation to develop and utilize common quality metrics, gather data on the health care outcomes of the full population, and evaluate and improve the performance of providers based on a large pool of patients that is not fragmented by insurance type, as is the case today. They also would enable the creation of uniform provider payment systems that reward high-quality care, standardization in health information technology, and the creation of universal processes to improve safety systematically across health care institutions.

⁴¹ Collins, Davis, and Kriss, *Congressional Health Care Bills*, 2007.

Are there specific provisions aimed at improving quality and efficiency in the health system? Proposals to expand health insurance should also be evaluated on the basis of their inclusion of specific measures to improve quality. Proposals that are designed to achieve universal health insurance coverage should be pursued simultaneously with health system reforms that improve quality and efficiency. Universal coverage should not be held hostage until a more efficient health system is achieved, but coverage should also not be expanded without the difficult work of ensuring that the health system is accessible, reliable, and consistently high-quality, and yields commensurate value for the resources invested. Key components of health reform proposals to achieve high performance include:

- Insurers should compete on providing added value to the health system in greater quality and efficiency, rather than on segmenting or excluding poor health risks.
- Payers (private insurers and public programs) should collaborate to negotiate with providers coherent policies and fair payment for health services and pharmaceutical products.
- Patient and provider incentives should be aligned to encourage use of all effective services, and avoid use of ineffective services or overutilization, duplication, and waste.
- All patients and providers should be part of an organized care system that is accessible and accountable for patient health outcomes, preventive care, and care coordination.
- Information on the cost and quality of care should be transparent and publicly available.
- The health care system should be patient-centered and the health environment should be supportive of leading healthy lives.
- The health system should be scientifically grounded.

Ultimately, what is needed to move the health care system to high performance is a coherent set of policies with goals and properly aligned incentives that move all participants in the system in the same direction—toward improving access, quality, equity, and efficiency for everyone. It is critical that all adults and children fully participate in a health care system that is well organized and is based on incentives that ensure that everyone receives the right care, at the right time, and in the right setting over their lifespan. It will not be productive in the long run if we focus overly on the impact of

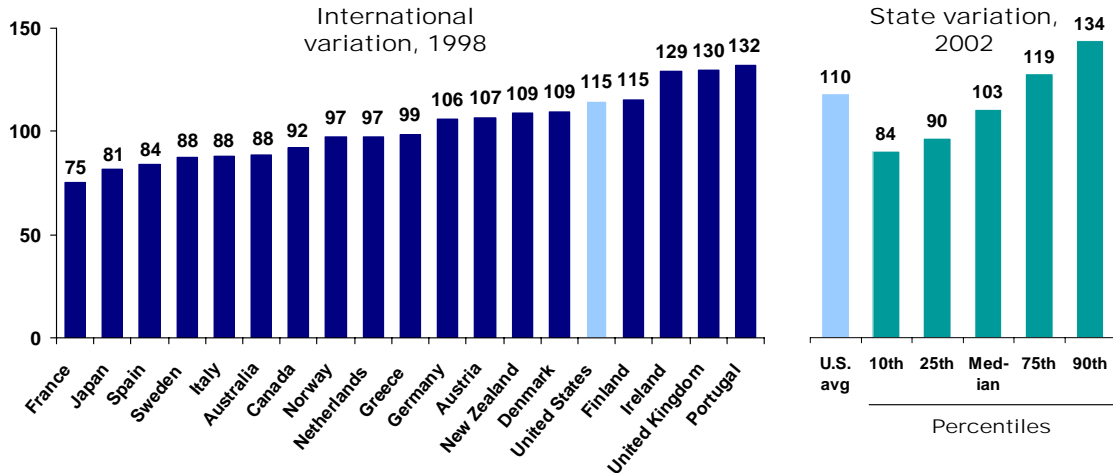
reform policies on the federal budget, or on the budgets of major corporations, or even the impact on our families' budgets. Instead, we can only move forward when we keep our eye on the number that really matters—the \$2 trillion that we spend as a nation on health care each year. This ultimately determines the size and growth of all participants' budgets and should be the focal point of our collective energies as we develop coherent, consistent, and equitable health care policy.

Thank you.

Figure 1. Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease.

See Technical Appendix for list of conditions considered amenable to health care in the analysis.

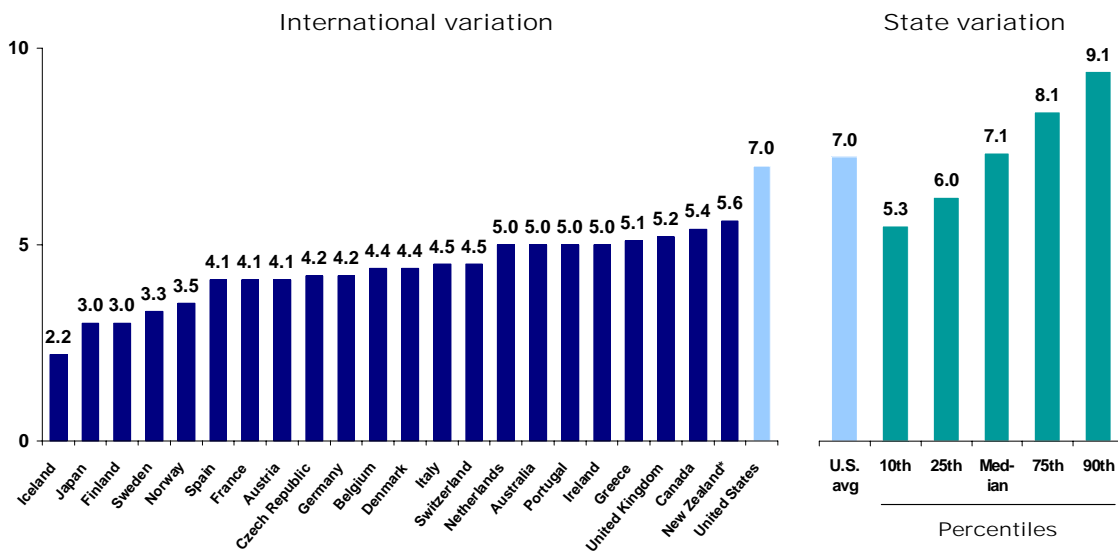
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003);

State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 2. Infant Mortality Rate, 2002

Infant deaths per 1,000 live births



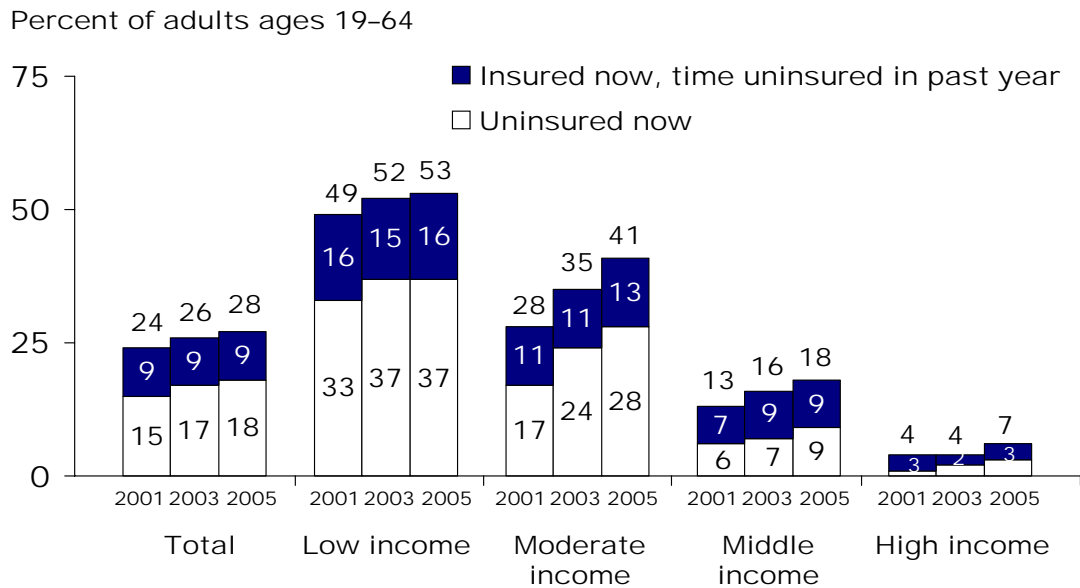
* 2001.

Data: International estimates—OECD Health Data 2005;

State estimates—National Vital Statistics System, Linked Birth and Infant Death Data (AHRQ 2005a).

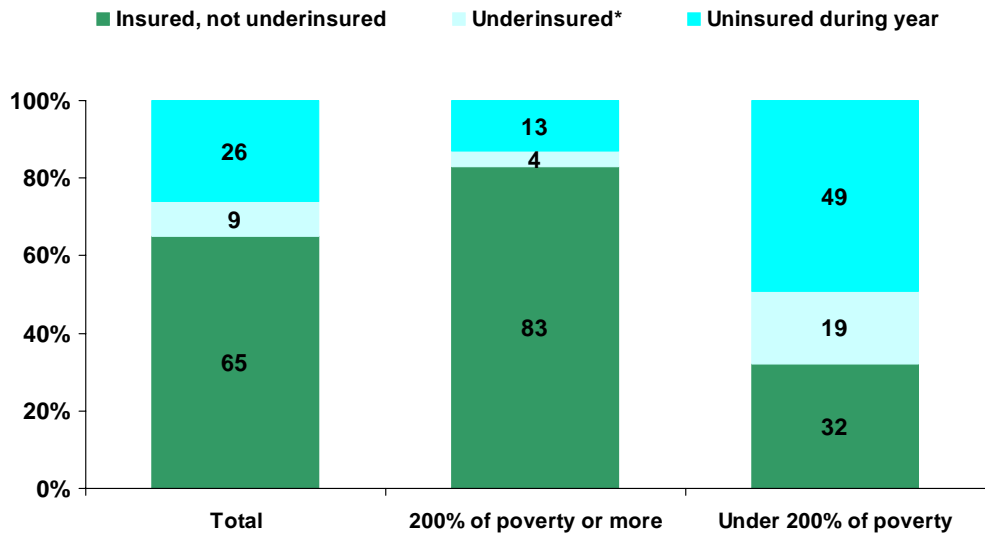
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 3. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005



Note: Income refers to annual income. In 2001 and 2003, low income is <\$20,000, moderate income is \$20,000–\$34,999, middle income is \$35,000–\$59,999, and high income is \$60,000 or more. In 2005, low income is <\$20,000, moderate income is \$20,000–\$39,999, middle income is \$40,000–\$59,999, and high income is \$60,000 or more. Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, April 2006.

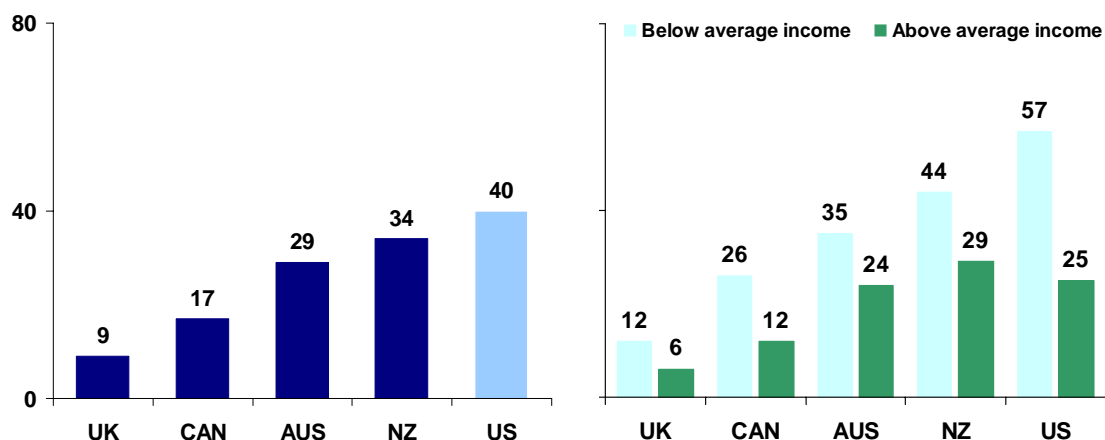
Figure 4. Adults Ages 19–64 Who Are Uninsured and Underinsured, by Poverty Status, 2003



* Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income. Data: 2003 Commonwealth Fund Biennial Health Insurance Survey (Schoen et al. 2005b). Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 5. Access Problems Because of Costs in Five Countries, Total and by Income, 2004

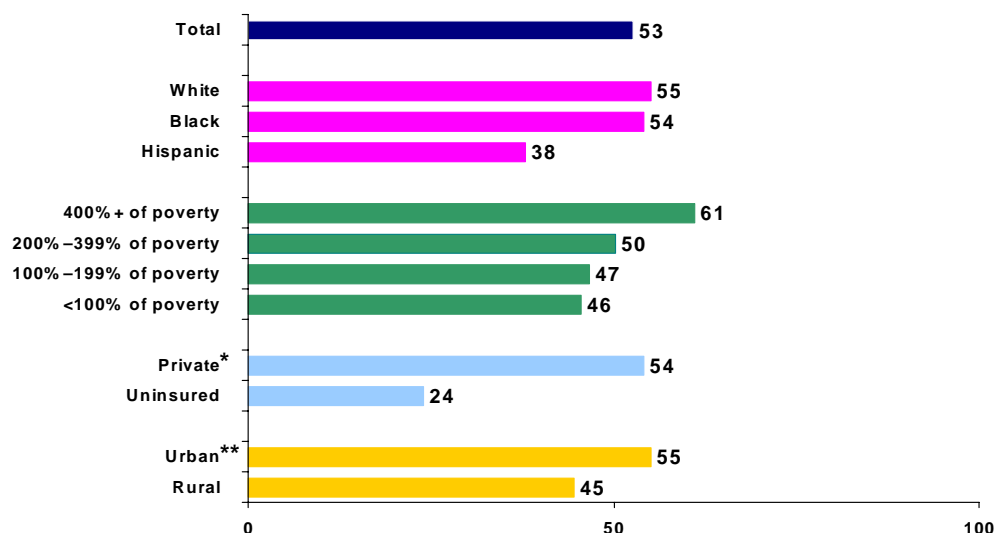
Percent of adults who had any of three access problems* in past year because of costs



* Did not get medical care because of cost of doctor's visit, skipped medical test, treatment, or follow-up because of cost, or did not fill Rx or skipped doses because of cost.
 UK=United Kingdom; CAN=Canada; AUS=Australia; NZ=New Zealand; US=United States.
 Data: 2004 Commonwealth Fund International Health Policy Survey of Adults' Experiences with Primary Care (Schoen et al. 2004; Huynh et al. 2006).
 Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 6. Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity, Family Income, Insurance, and Residence, 2002

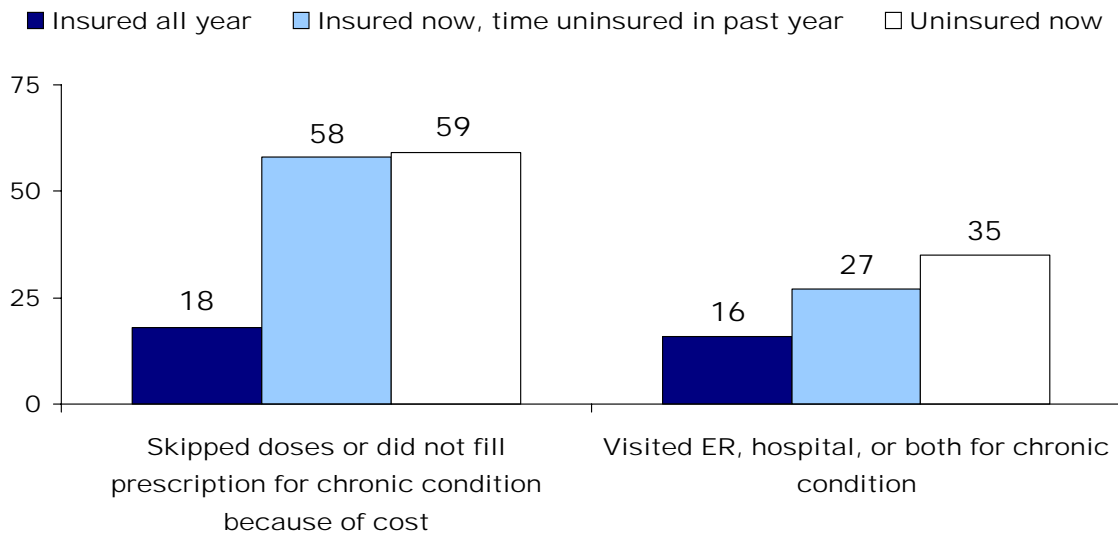
Percent of diabetics (ages 18+) who received HbA1c test, retinal exam, and foot exam in past year



* Insurance for people ages 18-64.
 ** Urban refers to metropolitan area ≥ 1 million inhabitants; Rural refers to noncore area $< 10,000$ inhabitants.
 Data: 2002 Medical Expenditure Panel Survey (AHRQ 2005a).
 Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 7. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

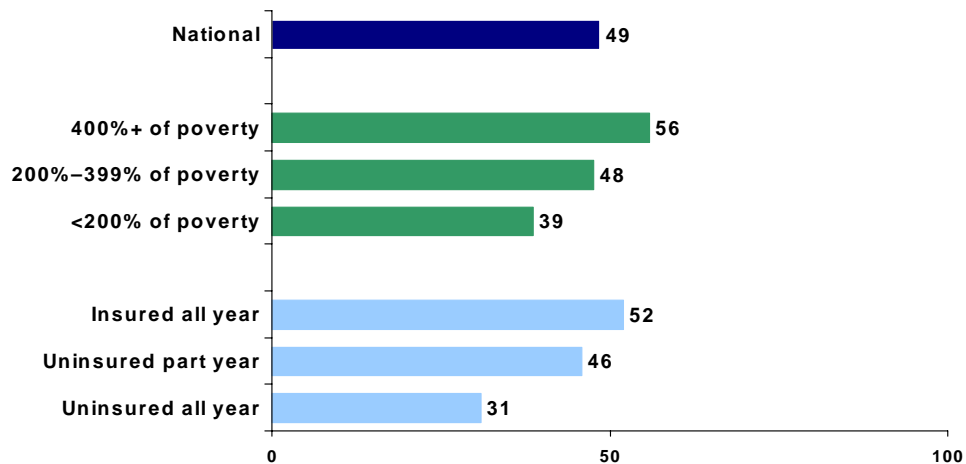
Percent of adults ages 19–64 with at least one chronic condition*



*Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.
Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem*, Findings from the Commonwealth Fund Biennial Health Insurance Survey (New York: The Commonwealth Fund, Apr. 2006).

Figure 8. Receipt of Recommended Screening and Preventive Care for Adults, by Family Income and Insurance Status, 2002

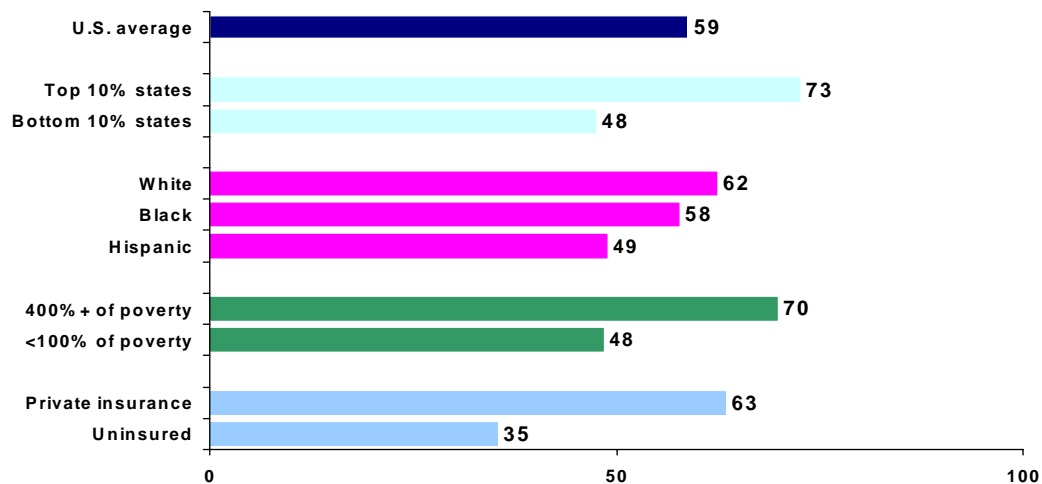
Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot.
Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 9. Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

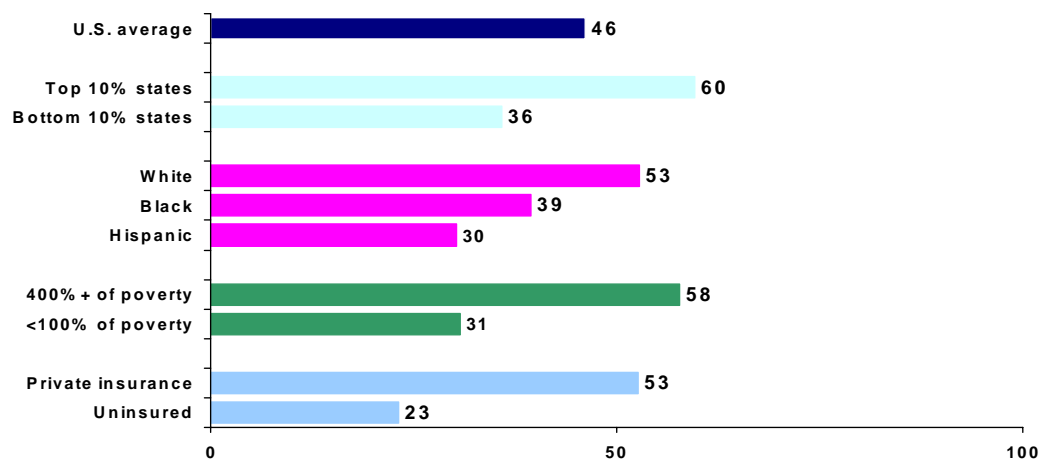
Percent of children (ages <18) received BOTH a medical and dental preventive care visit in past year



Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at <http://www.nschdata.org>).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 10. Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

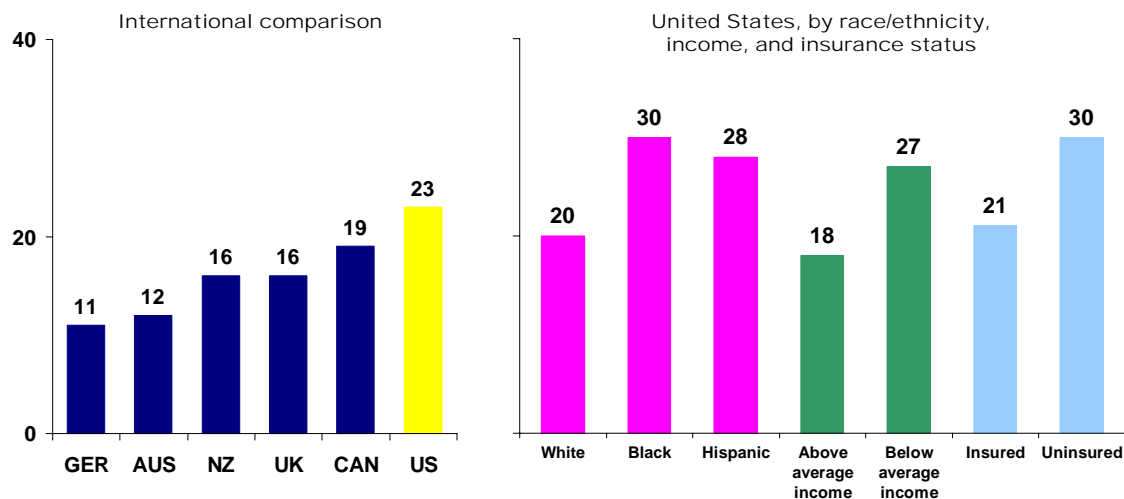
Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*



* Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child's specialty care visits.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at <http://www.nschdata.org>).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 11. Test Results or Medical Record Not Available at Time of Appointment, Among Sicker Adults, 2005

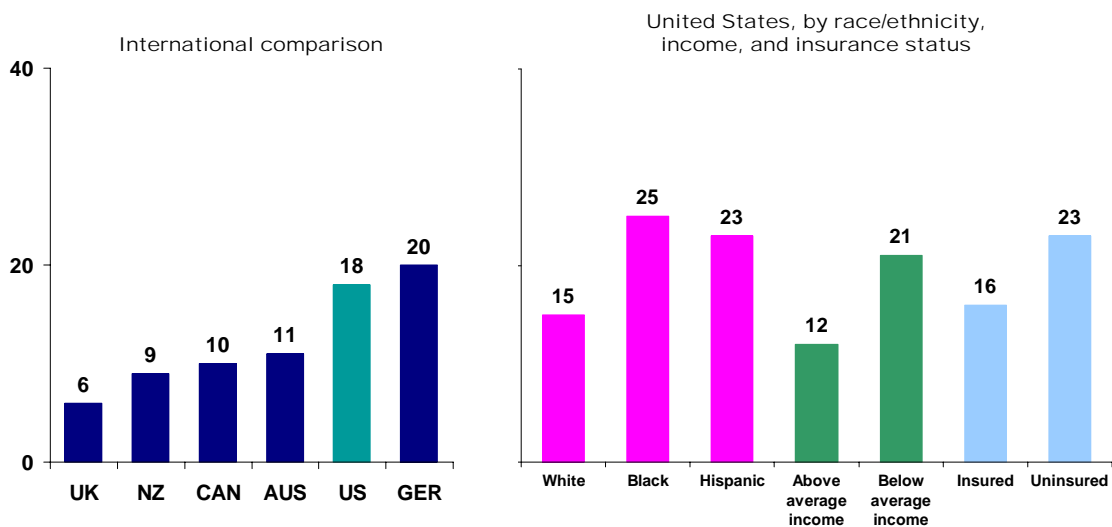
Percent reporting test results/records not available at time of appointment in past two years



GER=Germany; AUS=Australia; NZ=New Zealand; UK=United Kingdom; CAN=Canada; US=United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 12. Duplicate Medical Tests, Among Sicker Adults, 2005

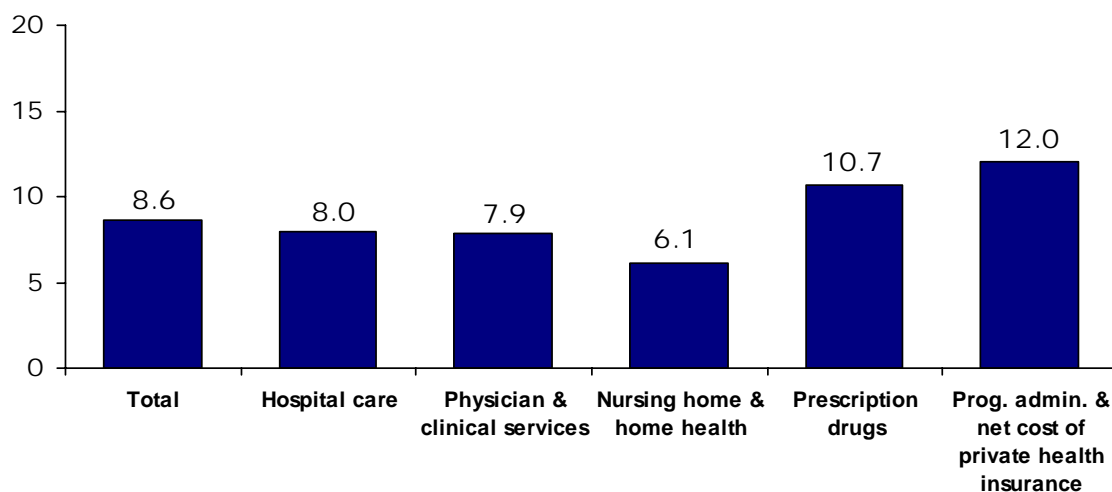
Percent reporting that doctor ordered test that had already been done in past two years



UK=United Kingdom; NZ=New Zealand; CAN=Canada; AUS=Australia; US=United States; GER=Germany.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 13. Health Expenditure Growth 2000–2005
for Selected Categories of Expenditures

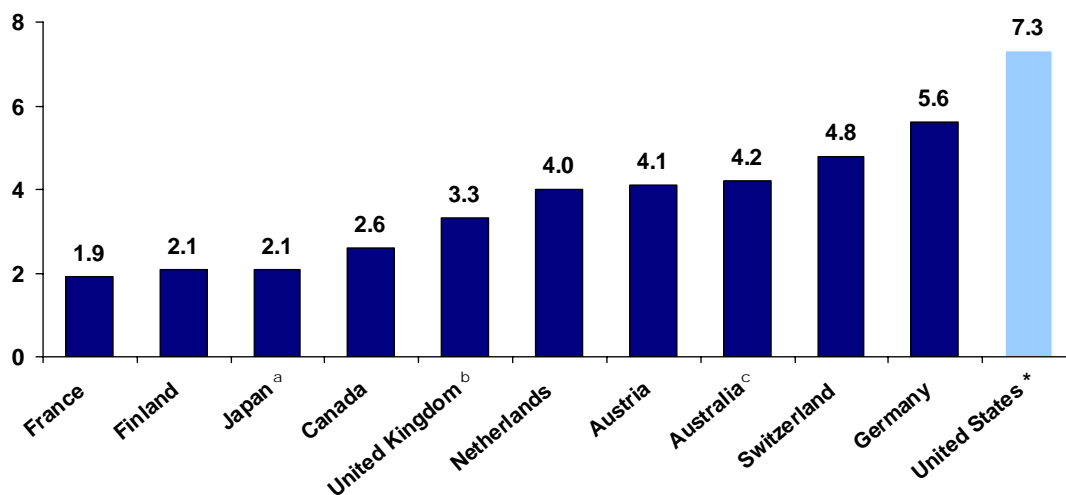
Average annual percent growth in health expenditures, 2000–2005



Source: A. Catlin et al., "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, Jan./Feb. 2007 26(1):142–53.

Figure 14. Percentage of National Health Expenditures
Spent on Health Administration and Insurance, 2003

Net costs of health administration and health insurance
as percent of national health expenditures



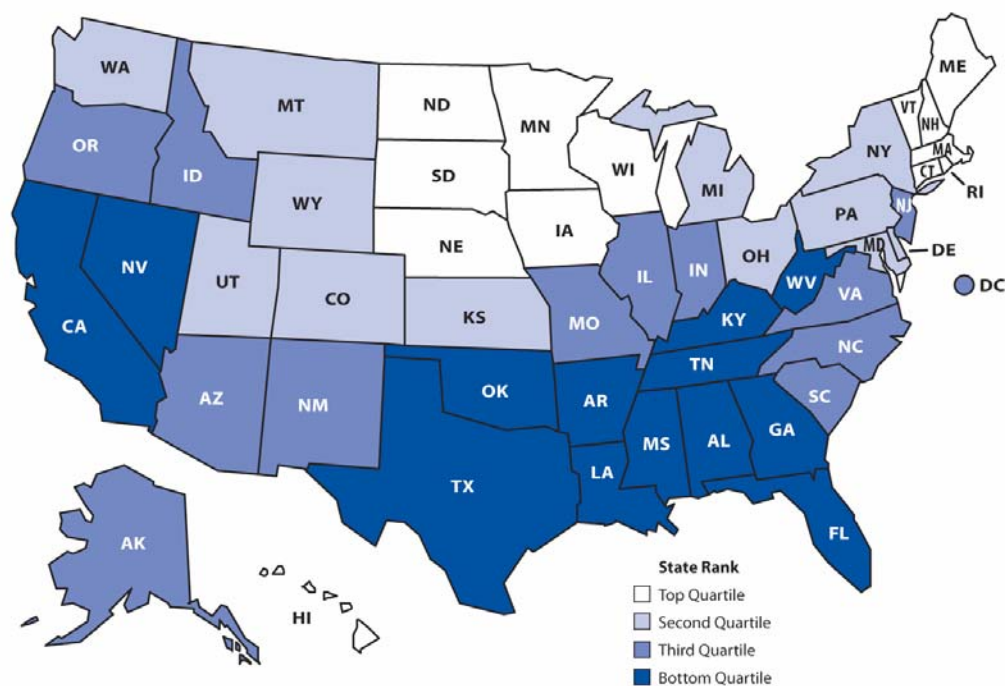
^a2002 ^b1999 ^c2001

^{*}Includes claims administration, underwriting, marketing, profits, and other administrative costs; based on premiums minus claims expenses for private insurance.

Data: OECD Health Data 2005.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

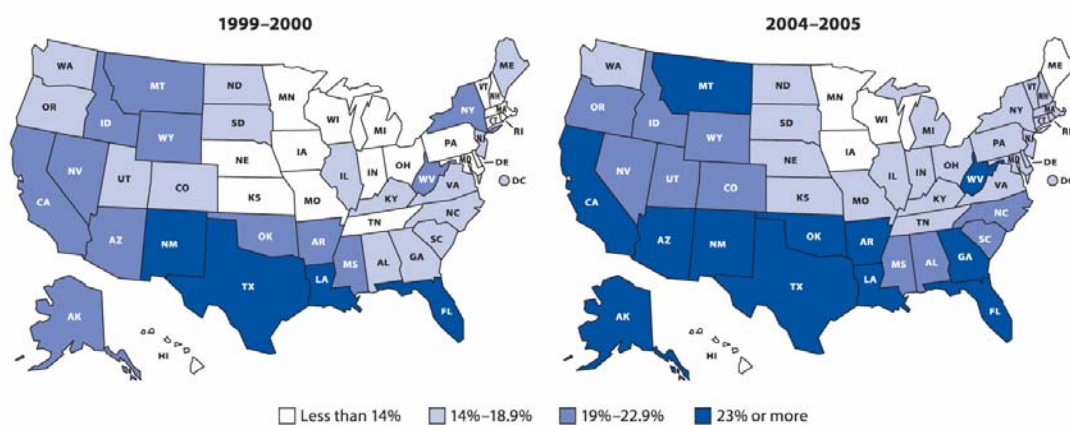
Figure 15. **State Ranking on Overall Health System Performance**



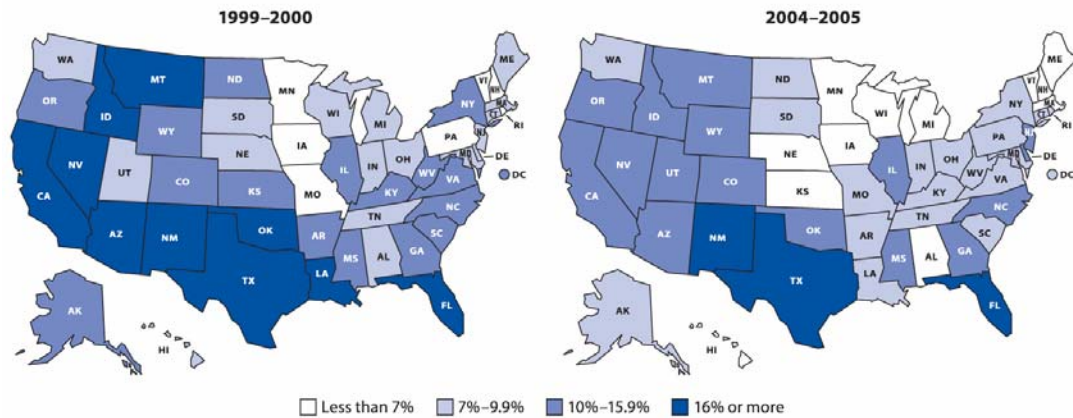
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

ACCESS

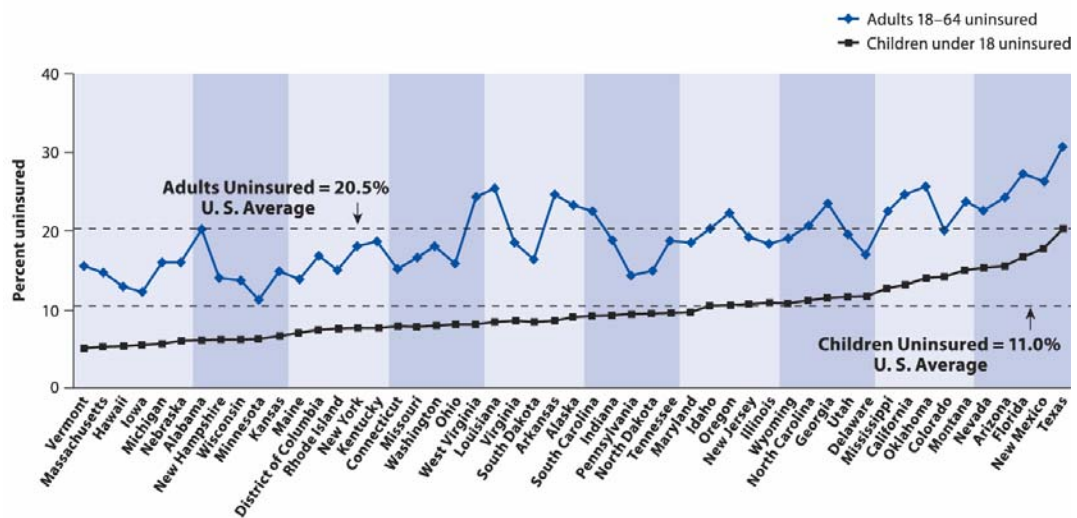
Figure 16. **Percent of Adults Ages 18–64 Uninsured by State**



DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

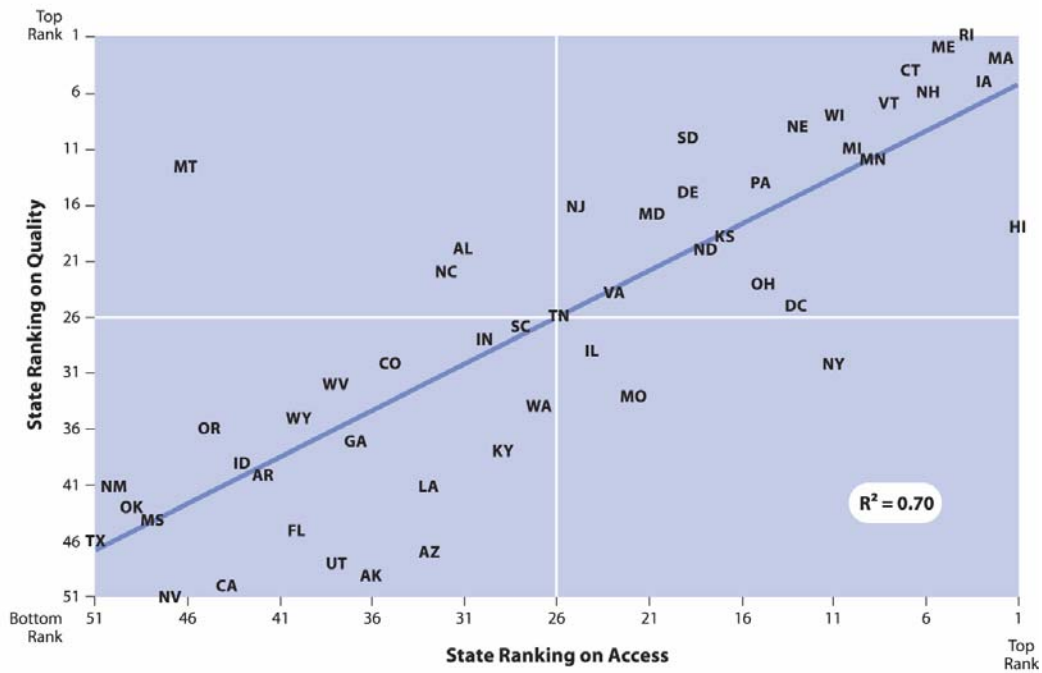
Figure 17. **Percent of Children Ages 0–17 Uninsured by State**

DATA: Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Survey
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Figure 18.
Percent of Adults and Children Uninsured by State, 2004–2005

DATA: Census Bureau's March 2005 and 2006 Current Population Survey
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Figure 19. **State Ranking on Access and Quality Dimensions**

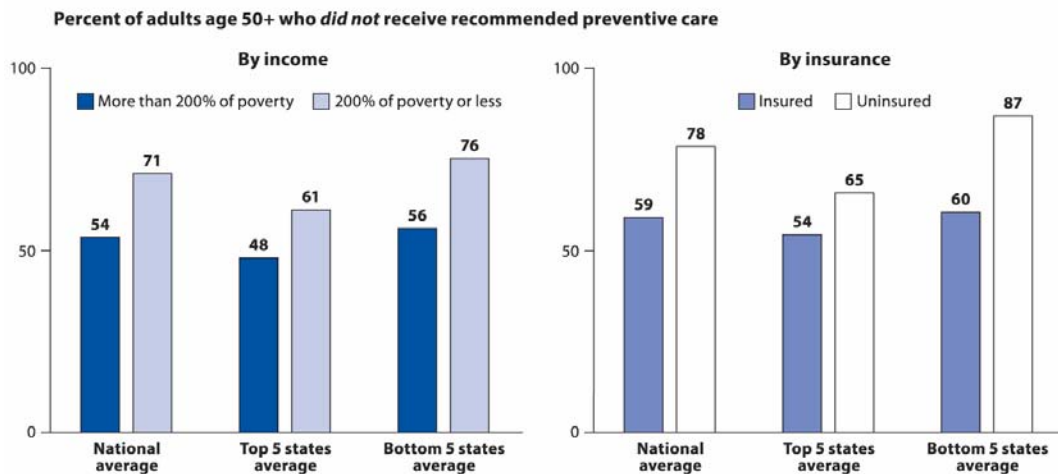


SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

EQUITY

Figure 20.

Lack of Recommended Preventive Care by Income and Insurance

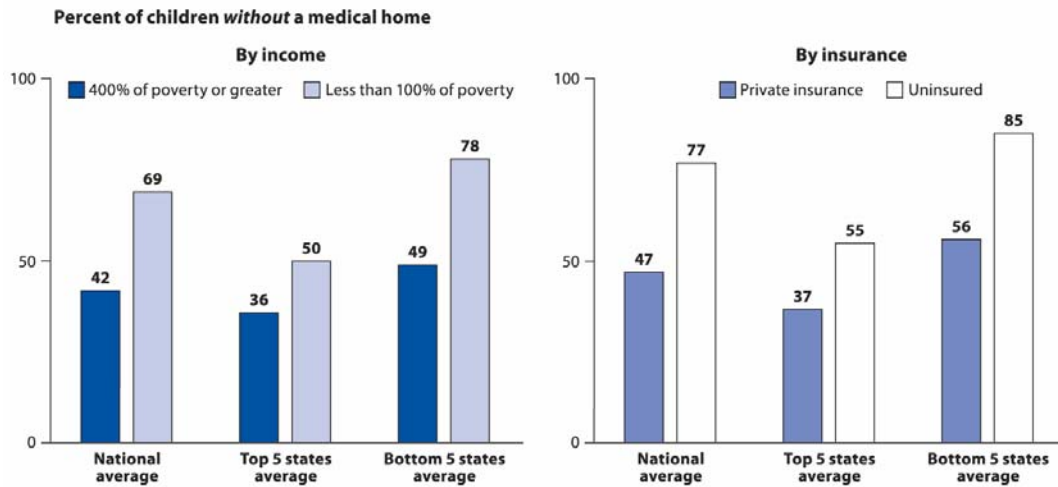


Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured.
Bottom 5 states refer to states with largest gap between national average and low income/uninsured.

DATA: 2002/2004 BRFSS

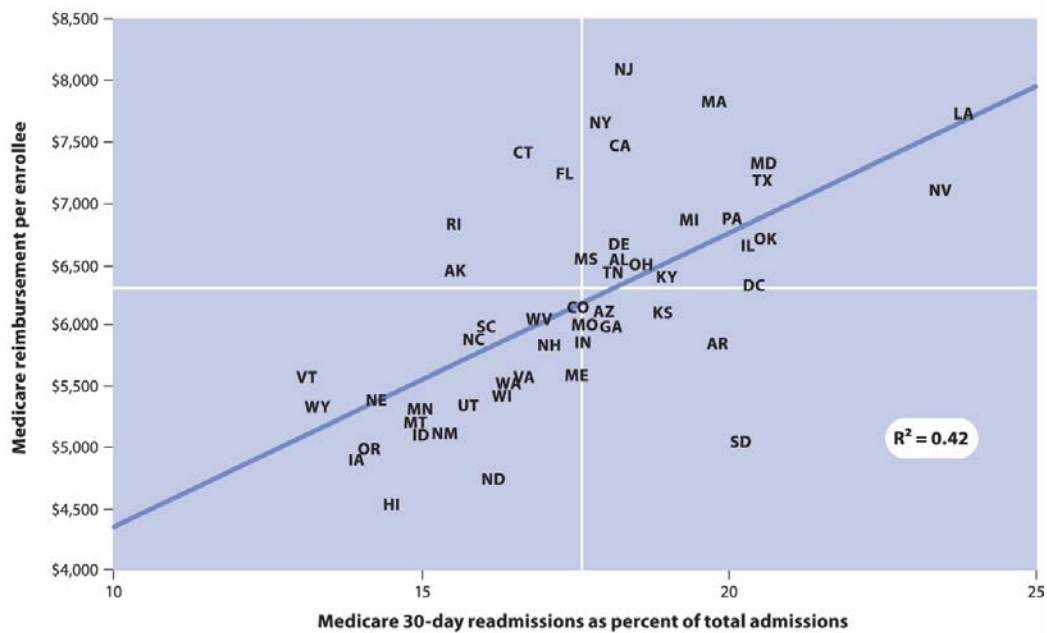
SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Figure 21.

Absence of a Medical Home by Income and Insurance

Note: Top 5 states refer to states with smallest gap between national average and low income/uninsured.
 Bottom 5 states refer to states with largest gap between national average and low income/uninsured.
 DATA: 2003 National Survey of Children's Health
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Figure 22.

Medicare Reimbursement and 30-Day Readmissions by State, 2003

DATA: Medicare reimbursement – 2003 Dartmouth Atlas of Health Care; Medicare readmissions – 2003 Medicare SAF 5% Inpatient Data
 SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

RELATED PUBLICATIONS

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